

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13584

CERTIFICATE OF DEATH

Reg. Dist. No.

13581 260

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ORIOLE</b>				c. LENGTH OF STAY IN 1b <b>LIFE TIME</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>ORIOLE</b> <b>x2</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>GRANVILLE BENSON</b>				4. DATE OF DEATH Month Day Year <b>12 31 1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/5/1879</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELLING FISH</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOLSTER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>							
13. FATHER'S NAME <b>EDWARD BENSON</b>				14. MOTHER'S MAIDEN NAME <b>HENNETTA TERPIN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MARY BENSON, PRINCESS ANNE, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Embolism of brain artery</b> DUE TO <b>332x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension &amp; arteriosclerosis</b> DUE TO <b>Senility</b> (c) <b>Senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 yrs.</b> <b>10 yrs.</b> <b>10 yrs.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Dec. 1956</b> , to <b>Dec. 31, 1957</b> , that I last saw the deceased alive on <b>Dec. 31, 1957</b> , and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. C. Lewis</b> M.D.				ADDRESS (Street, city or town, state) <b>Princess Anne, Md.</b> DATE SIGNED <b>1/2/58</b>			
PHYSICIAN'S NAME (Type) <b>A. C. Lewis, M.D.</b>				<b>Princess Anne, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/5/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST JAMES</b>		22d. LOCATION (City, town, or county) (State) <b>ORIOLE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Johnson</b> ADDRESS <b>Princess Anne, Md.</b>				24a. REC'D BY REGISTRAR <b>1958</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Dr. H. Johnson</b>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is mostly blank with some faint handwriting.

BUREAU V. S.

JAN 6 1958

RECEIVED

# CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE, MD</b>		c. LENGTH OF STAY IN 1b <b>64 years</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>princess anne X</b>		d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LILLIE CORBIN</b>						4. DATE OF DEATH Month Day Year <b>12 2 1957</b>									
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Approx. 64 yrs.</b>		9. AGE (In years last birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FACTORY</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SWANSON &amp; SON</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>					
13. FATHER'S NAME <b>ROBERT HALL</b>						14. MOTHER'S MAIDEN NAME <b>MARTHA JAMES</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>183-14-2056</b>		17. INFORMANT Address <b>SALLIE PURNELL, PRINCESS ANNE, MARYLAND</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b> <b>2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m. <b>none</b> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Princess Anne, Md.</b>		(County) <b>Maryland</b>		(State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>Sept 5, 1957</b> , to <b>Dec 2, 1957</b> , that I last saw the deceased alive on <b>Dec 2, 1957</b> , and that death occurred at <b>9:00 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>B. Frank Giganti</b> M.D. <b>20 Prince William St.</b> DATE SIGNED <b>Dec 4, 1957</b> PHYSICIAN'S NAME (Type) <b>B. FRANK GIGANTI</b> <b>Princess Anne, Md.</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST MARK</b>				22d. LOCATION (City, town, or county) <b>OAKVILLE</b>		(State) <b>Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Dunsen, Princess Anne, Md.</b>						24a. REC'D BY REGISTRAR DATE <b>10/1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. R. F. Johnson</b>							

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (o)

33/X

**DUE TO**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 mo

2 yr

20a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m.  
p. m. *none* 19

20d. INJURY OCCURRED  
While of work ☐ Not while of work ☐

20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

{County}

{State}

21. I certify that I attended the deceased from Sept 5, 1957, to Dec 2, 1957, that I last saw the deceased alive on Dec 2, 1957, and that death occurred at 9:00 AM, from the causes and on the date stated above.

**ACTUAL  
SIGNATURE**

PHYSICIAN'S  
NAME (Type)

B. Frank G. G.  
B. FRANK G. G.

M.D.

**ADDRESS** (Street, city or town, state)

DATE SIGNED \_\_\_\_\_

220. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF  
12/7/57

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE \_\_\_\_\_

ADDRESS

240. REC'D BY REGISTRAR

24b REGISTRAR'S SIGNATURE

DATE \_\_\_\_\_

W. K. K. Johnson

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

BUREAU V. 2

DEC 10 1957

RECEIVED

13583

## CERTIFICATE OF DEATH

Reg. Dist. No. 0265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gandy Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>EVANS, Sr.</b> Last <b>EVANS, Sr.</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>28</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19, 1890</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>67</b>	IF UNDER 24 HRS. Days <b>67</b> Hours <b>67</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Crabs &amp; Oysters</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Mouldin Evans</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Horner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-12-3537</b>		17. INFORMANT Address <b>James Evans, Jr.—Crisfield, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Hemoplegia, rt. side</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>331X</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 days.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 24, 1957</b> , to <b>Dec 28, 1957</b> , that I last saw the deceased alive on <b>Dec 28, 1957</b> , and that death occurred at <b>11:20 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b> DATE SIGNED <b>Dec 28, 1957</b>							
ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D.				DATE SIGNED <b>Dec 28, 1957</b>			
PHYSICIAN'S NAME (Type) <b>Dr. C. G. Rawley, M. D.</b>				Main St.—Crisfield, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 31, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Seng--Crisfield, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR DATE <b>12/31/57</b>		24b. REGISTRAR'S SIGNATURE <b>Barclay L. Adams</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

RECEIVED

Dec. 25

RECEIVED

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

Dec. 25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 224 1-23-58 et

13586

## CERTIFICATE OF DEATH

13585

Reg. Dist. No.

260

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE x 2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>LAURA V. FOOKS</b>				4. DATE OF DEATH Month Day Year <b>12 22 19 57</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Approx. 85</b>	
9. AGE (In years last birthday) <b>72</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>							
13. FATHER'S NAME <b>WILLIAM P. MADDOX</b>				14. MOTHER'S MAIDEN NAME <b>PRICIA FOUNTAIN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>WESLEY FOORS PRINCESS ANNE, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> <b>42222</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 12, 1955</b> to <b>Dec 22, 1957</b> , that I last saw the deceased alive on <b>Dec 21, 1957</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Eldon G. Markman M.D. Princess Anne, Md.</b>							
ACTUAL SIGNATURE <b>Eldon G. Markman</b>							
PHYSICIAN'S NAME (Type) <b>Princess Anne, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>JOHN WESLEY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCESS ANNE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WILLIAM H. JAMES JR PRINCESS ANNE, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>12/27/57</b>		24b. REGISTRAR'S SIGNATURE <b>R. J. [Signature]</b>	

# CERTIFICATE OF DEATH

BUREAU V. H.

50 30 1057

RECEIVED



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13587

13587

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manokin</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Manokin</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>7</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lucy</b> Middle <b>P.</b> Last <b>Hood</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>24</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1890</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>real estate broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>real estate</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry K. Preston</b>				14. MOTHER'S MAIDEN NAME <b>Anne Rhetta</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>?</b>		17. INFORMANT Address <b>Mr. Henry P. Mitchell, Kinston, N.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Burned - Body over half destroyed when house was destroyed by fire</b> DUE TO (b) <b></b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Home burned.</b>						INTERVAL BETWEEN ONSET AND DEATH <b></b>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fire destroyed home</b>					
20c. TIME OF INJURY Month, Day, Year <b>12-24-57</b> Hour <b>1130</b> a. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Manokin Somerset Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.H. Johnson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>R.H. Johnson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>December 27-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>12-27, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Andrew Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levin Wilson</b>				24a. REC'D BY REGISTRAR <b>12/27/57</b>		24b. REGISTRAR'S SIGNATURE <b>R.H. Johnson, M.D. (jr)</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
BUREAU V. 2

RECEIVED  
BUREAU V. 2

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13588 CERTIFICATE OF DEATH

13588

Reg. Dist. No. 2600

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAMES QUARTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAMES QUARTER</u>			
c. LENGTH OF STAY IN 1b <u>LIFE TIME</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR WILLIE JONES</u>				4. DATE OF DEATH Month Day Year <u>12 10 19 57</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/4/1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>GEORGE W. JONES</u>				14. MOTHER'S MAIDEN NAME <u>MARY ROBERTS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>ELLA JONES, DAMES QUARTER, MARYLAND</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>4000</u> DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12-5-57</u> , 19 <u>57</u> , to <u>12-10-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-10-57</u> , 19 <u>57</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Everett C. Sutter</u> M.D.							
PRINTED NAME (Type) <u>Everett C. Sutter MD</u>				<u>Dames quarter, Maryland 12-12-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>CREMATION</u>		<u>12/14/57</u>		<u>DAMES QUARTER</u>		<u>DAMES QUARTER, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Jones</u>				ADDRESS <u>1313 1/2</u>		24a. REC'D BY REGISTRAR DATE <u>12/13/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>K. S. Wilson</u>			

U. S. A.



## CERTIFICATE OF DEATH

Reg. Dist. No. 265

13589

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cristfield</u>				c. LENGTH OF STAY IN 1b <u>Marion Station</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>McCready Hospital</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Rosie</u> Middle <u>E.</u> Last <u>Logan</u>				4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1882</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Bloxom, Accomac Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Littleton Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <u>216-14-278</u>		17. INFORMANT <u>Beulah Rice</u>		Address <u>Marion Station, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Condition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes + C. Int. Nephritis +</u> DUE TO (c) <u>Chronic Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 8, 1955</u> to <u>Dec. 8, 1957</u> , that I last saw the deceased alive on <u>Dec. 8, 1957</u> , and that death occurred at <u>7:30 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George C. Coulbourn M.D.</u>				ADDRESS (Street, city or town, state) <u>Marion Sta. Md.</u>		DATE SIGNED <u>12-11-57</u>	
PHYSICIAN'S NAME (Type) <u>George C. Coulbourn, M.D.</u> <u>Marion Station, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/12/57</u>		22c. NAME OF CEMETERY OR CREMATOR <u>Waters Family</u>		22d. LOCATION (City, town, or county) (State) <u>Marion Sta, Som. Co, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>				ADDRESS <u>Marion Sta., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>12/14/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Nellie D. Payne</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



316-14-122

RECEIVED

1957

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13590

## CERTIFICATE OF DEATH

13591

Reg. Dist. No. 245

1 PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>29</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McGready Hospital</b>		d. STREET ADDRESS <b>323 Locust St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>G.</b> Last <b>MYERS, Sr.</b>		4. DATE OF DEATH Month <b>December</b> Day <b>23,</b> Year <b>19 57</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1879</b>
9. AGE (In years lost birthday) <b>78</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>	
11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Myers</b>		14. MOTHER'S MAIDEN NAME <b>Emma Richardson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tot. no. or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO <b>213-22-5096</b>	
17. INFORMANT <b>Mrs. Ella M. Myers, 323 Locust St., Crisfield</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio-sclerosis</b> <b>422.2</b> DUE TO <b>Arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary artery</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 5, 1957</b> to <b>Dec 23, 1957</b> that I last saw the deceased alive on <b>Dec 22, 1957</b> , and that death occurred at <b>1:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>George C. Coulbourn</b> M.D.			
PRINTED NAME (Type) <b>George C. Coulbourn, M. D.</b>		<b>Marion Station, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/25/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>12/31/57</b>		24b. REGISTRAR'S SIGNATURE <b>Barbara S. Malone</b>	

U. S. ARMY

RECEIVED

U. S. ARMY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13592

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>McCreedy Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RALPH</u> First <u>NELSON</u> Last		4. DATE OF DEATH <u>DEC. 22</u> Month <u>1957</u> Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar-2-1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Retired Waterman Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>LORENZO NELSON</u>		14. MOTHER'S MAIDEN NAME <u>HARRIETT LAWSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>215-05-5720</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> (c) <u>Renal Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 19, 1957</u> to <u>Dec. 22, 1957</u> , that I last saw the deceased alive on <u>Dec. 22, 1957</u> , and that death occurred at <u>4:00</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah M. Peyton</u> M.D.		ADDRESS (Street, city or town, state) <u>33 W. Main St - Crisfield Md</u>	
PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton</u>		DATE SIGNED <u>12/20/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/24/57</u>	22c. NAME OF CEMETERY <u>Asbury M.E.</u>	22d. LOCATION (City, town, or county) (State) <u>Crisfield Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. W. Johnston</u>		24a. REC'D BY REGISTRAR <u>12/31/57</u>	24b. REGISTRAR'S SIGNATURE <u>Betha S. Adams</u>

U.S. A.

NO. 103

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No.

135930

13592

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE</b>	
c. LENGTH OF STAY IN 1b <b>LIFE TIME</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BLANCHE</b> First <b>NISKEY</b> Last		4. DATE OF DEATH Month <b>12</b> Day <b>25</b> Year <b>1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/7/1898</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE WORK</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>		13. FATHER'S NAME <b>?</b>	
14. MOTHER'S MAIDEN NAME <b>ELLA PEARL DOANE PRINCESS ANNE, ID</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>ELLA PEARL DOANE PRINCESS ANNE, ID</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomas of Rectum</b> <b>104X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>Nov 20, 1957</b> , to <b>Dec 25, 1957</b> , that I last saw the deceased alive on <b>Dec 23rd 1957</b> , and that death occurred at <b>3:24 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Eldon G. Marksman</b> M.D. <b>Princess Anne</b> PHYSICIAN'S NAME (Type) <b>Eldon G. Marksman</b> <b>Princess Anne</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12/29/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>JOHN WESLEY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCESS ANNE, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WILLIAM H. JAMES JR</b>		24a. REC'D BY REGISTRAR <b>DEC 30 1957</b>	24b. REGISTRAR'S SIGNATURE <b>R. R. Johnson</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, 4, and 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

EC 30 1957

BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Affix this certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12 Film 6224 1-27-58 et

13594

13593

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Crisfield</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Crisfield x0</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>R. 240</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R. 240</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Angie</u> Middle <u>L.</u> Last <u>Sterling</u>		4. DATE OF DEATH Year <u>1957</u> Month <u>Dec</u> Day <u>24</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 1 1871</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Crisfield, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry C. Sterling</u>		14. MOTHER'S MAIDEN NAME <u>Sallie H. Sterling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Richard Gordon R. H. Crisfield</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - (generalized)</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus ulcers</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>1955</u> , 19 <u>  </u> , to <u>Dec. 24, 1957</u> , that I last saw the deceased alive on <u>Dec. 22, 1957</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Sarah M. Peyton</u> M.D. <u>Crisfield, Md.</u>		DATE SIGNED <u>Dec 26, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Dec 36, 1957</u>	<u>Family Cemetery</u>	<u>Crisfield Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Hannon</u>		24. REGISTRAR'S SIGNATURE <u>Barbara S. Adams</u>	
ADDRESS <u>Crisfield Md.</u>		DATE <u>12/31/57</u>	

RECEIVED  
JAN 10 1969  
U.S. AIR FORCE

13594

## CERTIFICATE OF DEATH

Reg. Dist. No.

265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>since birth</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>INFANT</b> Middle <b>GIRL</b> Last <b>STEVENSON</b>		4. DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1957</b>
9. AGE (In years last birthday) yrs. <b>3</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Mins <b>3 3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Albert Adkins</b>		14. MOTHER'S MAIDEN NAME <b>Zelda Stevenson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT Address <b>Zelda Stevenson—139 Tyler St.—Crisfield, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (d), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>accident</b> <b>X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO (c) <b>---</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 9, 1957</b> to <b>Dec. 9, 1957</b> , that I last saw the deceased alive on <b>Dec. 9, 1957</b> , and that death occurred at <b>8:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Main St.—Crisfield, Md.</b> DATE SIGNED <b>Dec 10 1957</b>			
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Sarah M. Peyton, M. D.</b>		<b>Main St.—Crisfield, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 10, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons—Crisfield, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR DATE <b>12/20/57</b>	24b. REGISTRAR'S SIGNATURE <b>Bradshaw &amp; Sons</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7817 2X-1



RECEIVED W. S.

DEC

13595

## CERTIFICATE OF DEATH

Reg. Dist. No.

261

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D.</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Marion Station, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>THURMAN</b> Middle <b>CHARLES</b> Last <b>TAYLOR, SR.</b>				4. DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1888</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>near Marion Station, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William T. Tayler</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Major</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes; no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. Lettie Tayler—R.F.D. Marion Station, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Condition - Myocarditis &amp; Angina</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (a) <b>Operated on at H. S. P. H. Hosp. Balto., Md. for Carcinoma of prostate</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Marion Station, Md.</b>		20g. (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 10, 1957</b> to <b>Dec. 28, 1957</b> , that I last saw the deceased alive on <b>12-28, 1957</b> , and that death occurred at <b>8:00A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Marion Station, Md.</b> DATE SIGNED <b>12-30-57</b>							
ACTUAL SIGNATURE <b>George C. Coulburne</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. George C. Coulburne, M.D.</b> <b>Marion Station, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 30, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Marion Station, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>12-30-57</b>		24b. REGISTRAR'S SIGNATURE <b>Nellie D. Payne</b>	

1 HOSPITAL OR ATTENDING PHYSICIAN: The low equi that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

JAN 3 1960

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13598

13596

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monie</b>			c. LENGTH OF STAY IN 1b <b>Life time</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monie</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellen</b> Last <b>Waters</b>				4. DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>?</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>?</b>		17. INFORMANT Address <b>Louis Bounds - Rt. 3 - Princess Anne, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Heart Disease.</b></p> <p>DUE TO (b) <b>Died in her sleep.</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)</p> </div> <div style="width: 10%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.H. Johnson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.H. Johnson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dec 27-1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-29-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grace Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Venton, Somerset Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. James Jr</b>				24a. REC'D BY REGISTRAR DATE <b>12/28/57</b>		24b. REGISTRAR'S SIGNATURE <b>R.H. Johnson, M.D.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

Write covering about Bureau.  
Bred in the valley.

✓  
U.S.

DEC

✓  
1927-1928

✓  
R.H. Johnson  
R.H. Johnson



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13597

## CERTIFICATE OF DEATH

13599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SAN JOSE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pocomoke</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke City</u> X1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RED #1</u>				d. STREET ADDRESS <u>RED #1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mollie Johnson Waters</u>				4. DATE OF DEATH Month Day Year <u>December 30 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1888</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George Collins</u>				14. MOTHER'S MAIDEN NAME <u>Vina Cluff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-26-3134</u>		17. INFORMANT <u>John Waters Westover, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Obesity</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>October 8, 1957</u> , that I last saw the deceased alive on <u>Oct 8, 1957</u> , and that death occurred at <u>2 a. m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>N. E. Sartorius Sr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Market Street</u>		DATE SIGNED <u>12/31/57</u>	
PHYSICIAN'S NAME (Type) <u>N. E. Sartorius Sr.</u>				<u>Pocomoke City, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-3-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Union B. M. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Pocomoke City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>				ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 1/5 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. Lucille Byrd</u>			

U. S. A.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13601

13598

Item: Film-224 1-3-58 et

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b Life time	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Williams		4. DATE OF DEATH Month Day Year December 27, 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1921
9. AGE (In years last birthday) 36 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Williams	
14. MOTHER'S MAIDEN NAME Hattie Dennis		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Hattie Dennis - Princess Anne, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 624X DUE TO Virus pneumonia Conditions, if any, which gave rise to immediate cause (b) Salpingitis with peritonitis (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE R. H. Johnson M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) R. H. Johnson ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED December 28-1957 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12/31/57 22c. NAME OF CEMETERY OR CREMATORY John Wesley Cen 22d. LOCATION (City, town, or county) (State) Princess Anne, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William A. James Jr Princess Anne Md 24a. REC'D BY REGISTRAR DATE 12/30/57 24b. REGISTRAR'S SIGNATURE R. H. Johnson, M.D.			

Not + bcs; - a / m.  $\frac{1}{2}$  a /  $\frac{1}{2}$  r  
at

THOMAS V. S.

DEC 21 1967

RECEIVED

13599 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13602  
160

Item 14, Film G224, 1/21/58

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmount</b>				c. LENGTH OF STAY IN 15 <b>60 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bertie</b> Middle <b>M.</b> Last <b>Windsor</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 13, 1877</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William Ford</b>				14. MOTHER'S MAIDEN NAME <b>Clementine Ford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Cecil Ford Fairmount, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.1</b> DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) <b>Senility</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>10 yrs.</b> <b>10 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 29, 1956</b> to <b>Dec. 29, 1957</b> , that I last saw the deceased alive on <b>Dec. 29, 1957</b> , and that death occurred at <b>5:45 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Princess Anne, Md.</b> DATE SIGNED <b>12/31/57</b> ACTUAL SIGNATURE <b>A.C. Lewis</b> M.D. <b>Princess Anne, Md.</b> PHYSICIAN'S NAME (Type) <b>A.C. Lewis, M.D.</b> <b>Princess Anne, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>1-2-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairmount cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fairmount, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lewis Wilson</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 3 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>R. J. Johnson</b>			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
William Bond		Male		80 years		Jan 15, 1953	
Place of Birth		Race		Marital Status		Cause of Death	
Maryland		White		Married		Heart Disease	
Occupation		Education		Usual Residence		Place of Death	
Farmer		High School		Home		Home	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. E.

JAN 3 1953

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13600 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13603

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHANCE</b>		c. LENGTH OF STAY IN 1b <b>5 MONTH</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHANCE</b> <b>x2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ETTA</b> Middle <b>ANN</b> Last <b>WRIGHT</b>				4. DATE OF DEATH Month <b>12</b> Day <b>21</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/16/57</b>	
9. AGE (In years last birthday) yrs. <b>6</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>21</b> Hours <b>19</b> Min. <b>57</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>			
13. FATHER'S NAME <b>RUFUS H. WRIGHT</b>				14. MOTHER'S MAIDEN NAME <b>DELORES M. SELBY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>DELORES WRIGHT ORIOLE, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronch pneumonia -</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 days -</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.H. Johnson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.H. Johnson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <b>Dec 23 - 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/24/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST CHARLES</b>		22d. LOCATION (City, town, or county) (State) <b>CHANCE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Jones</b>				24a. REC'D BY REGISTRAR <b>12-23-57</b>		24b. REGISTRAR'S SIGNATURE <b>R.H. Johnson</b>	

MINISTRE DU STAT DEPARTMENT OF HEALTH - EASTING 11  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(3000)

3 days -

Branch physician -

BUREAU V. E.

DEC 30 1957

RECEIVED  
DEC 30 - 1957

R. H. Johnson  
R. H. Johnson

15-5-3-3 R. H. Johnson